## Clinical Practice Guidelines: Neurological/Autonomic dysreflexia

<table>
<thead>
<tr>
<th>Policy code</th>
<th>CPG_NE_AUD_0722</th>
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<tr>
<td>Date</td>
<td>July, 2022</td>
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<tr>
<td>Purpose</td>
<td>To ensure consistent management of patients with autonomic dysreflexia.</td>
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<td>Scope</td>
<td>Applies to Queensland Ambulance Service (QAS) clinical staff.</td>
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<td>Health care setting</td>
<td>Pre-hospital assessment and treatment.</td>
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<tr>
<td>Population</td>
<td>Applies to all ages unless stated otherwise.</td>
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<tr>
<td>Source of funding</td>
<td>Internal – 100%</td>
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<tr>
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Autonomic dysreflexia (AD) is a syndrome of massive imbalanced reflex sympathetic discharge occurring in patients with an existing, non-acute spinal cord injury above the level of T6. This condition can be caused by a number of different noxious stimuli, including:

- distended bladder due to blocked/kinked catheter
- urinary tract infection
- bowel irritation (e.g. constipation/faecal impaction)
- skin irritations (e.g. pressure sores, ingrown toenails, burns, sunburn)
- contracting uterus, fractures or any other event that would normally be deemed painful.

Patients and carers know about this condition and should be asked if they suspect a cause. Removal of the noxious stimuli is the preferred management, however, as this can often be difficult within the pre-hospital environment, symptomatic management to prevent cerebrovascular catastrophe and other complications is more often the primary goal.

Complications from AD occur due to sustained, severe peripheral hypertension and include cerebral haemorrhage, myocardial infarction and seizures.

### Clinical features
- Relative hypertension (BP for quadriplegics and high level paraplegics is typically low when lying and even lower when sitting (≥ 90–100/60 mmHg may be significant)
- Flushing of skin above the level of injury or paleness below level of injury
- Bradycardia
- Profuse sweating and piloerection above the level of injury
- Pounding headache (worsening symptoms as BP rises)
- Blurred vision, headache, CVA/TIA symptoms
- Acute coronary syndrome (ACS)
- Anxiety and apprehension
- Irritability/combative behaviour in people with limited cognitive/communication ability

### Risk assessment
- A variety of symptoms can vary in intensity, from being asymptomatic or mild discomfort (e.g. headache) to a life threatening emergency
Consider:

- GTN
- Morphine OR fentanyl

Note: Clinicians must only perform procedures for which they have received specific training and authorisation by the QAS.

- Sit patient upright with legs dependent where possible to help lower BP
- Loosen or remove any tight clothing
- Ensure indwelling catheter or suprapubic catheter is not kinked
- Remove noxious stimuli if possible
- Avoid any pressure to the patient’s abdomen

Transport to hospital
Pre-notify as appropriate